CANNON BUILDING
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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL PRACTICE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

VERIFICATION OF PHYSICIAN LICENSE

Send a separate form to *each* jurisdiction other than Delaware where you have ever held a license to practice medicine.

Licensing Authority:_____	Applicant Name: _____
Address:_____	Home Address: _____
City/State/Zip: _____	City/State/Zip: _____

This section is to be completed by applicant.	Last Name:_____ First:_____ Middle: _____ SSN:_____ DOB:_____ Other Name(s) Used: _____ License Number(s) in Jurisdiction Named Above: _____ **I am applying for licensure as a Physician in the State of Delaware. Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the Delaware Board of Medical Practice.** This includes any medical training licenses. **Applicant Signature:** _____ Date: _____
This section to be completed by Licensing Authority	Our records indicate that the applicant named above was licensed in the State/Province/Jurisdiction of _____ License Number: _____ Issue Date (mm/dd/yyyy): _____ Expiration Date (mm/dd/yyyy): _____ Has any discipline activity taken place regarding this licensee? Yes ☐ No ☐ **If yes, please enclose a certified copy of the Board Order with this license verification.**
CERTIFICATION **AFFIX** **OFFICIAL** **SEAL HERE**	**Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.** **Printed Name of Official:** _____ **Signature of Official:** _____ **Date:** _____ **Title:**_____ **Phone:** _____ **Fax:** _____ **Email:**_____

***Mail* (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.**